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New York City Health and Hospitals Corporation v. Perales: Unclear Congressional Intent, Permissible Agency Interpretation

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COMMENTS

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION v. PERALES: UNCLEAR CONGRESSIONAL INTENT, PERMISSIBLE AGENCY INTERPRETATION

INTRODUCTION

The enactment of the Social Security Amendments of 1965¹ represented a milestone in American health care financing.² The Amendments included the addition of Titles XVIII and XIX, the Medicare³ and Medicaid⁴ programs, respectively. Medicare is a nationwide, federally funded insurance program which provides for medical care cost reimbursement primarily to beneficiaries aged 65 and over, regardless of income or wealth.⁵ The program is divided into two parts: Part A (basic insurance), which provides for inpatient hospital care,⁶ and Part B (supplemental insurance), which

¹ Pub. L. No. 89-97, 79 Stat. 286 (1965); *see also* Social Security Act of 1935, 49 Stat. 620 (1935) (original Social Security legislation to which Amendments were added).

² *See* MARGARET GREENFIELD, *MEDICARE AND MEDICAID: THE 1965 AND 1967 SOCIAL SECURITY AMENDMENTS v* (1968) ("by far the broadest extension of the social insurance principle in the 30-year history of American social security").

³ 42 U.S.C.A. §§ 1395-1395ccc (West 1992).

⁴ *Id.* §§ 1396-1396u.

⁵ *See* ROBERT J. BUCHANAN & JAMES D. MINOR, *LEGAL ASPECTS OF HEALTH CARE REIMBURSEMENT* 17 (1985) (anyone 65 or over qualifying for monthly Social Security benefits is entitled to Medicare); *see also infra* notes 8-15 and accompanying text (discussing details of Medicare eligibility).

⁶ *See* 42 U.S.C.A. §§ 1395c-1395i-4(k); *id.* § 1395c (Part A "provides basic protection against the costs of hospital, related post hospital, home health services, and hospice care"); *see also* S. REP. NO. 404, 89th Cong., 1st Sess. 4-6 (1965), *reprinted in* 1965 U.S.C.A.N. 1943, 1946-48 (description of Part A services). *See generally* Lynn M. Etheredge, *Overview: The Need for Reform, in* *MEDICARE PHYSICIAN PAYMENT REFORM: ISSUES AND OPTIONS* 1, 2

provides for certain physician services, hospital outpatient services, and other health care services generally not covered under Part A.⁷

Medicare Part A enrollment is automatic upon eligibility⁸ and generally does not require a monthly premium.⁹ Under Part A, when a beneficiary receives medical care for a covered service, 100% of the health care provider's "reasonable cost" is paid for by the federal government.¹⁰ In contrast, Medicare Part B enrollment is voluntary¹¹ and requires a monthly premium.¹² Under Part B, the federal government only pays 80% of reasonable cost,¹³ with the remaining 20% the responsibility of the beneficiary.¹⁴ This 20% is known as "coinsurance."¹⁵

(John F. Holahan & Lynn M. Etheredge eds., Urban Inst. Press) (1986) ("hospital costs . . . accounted for nearly 70 percent of Medicare spending"); HARVEY L. McCORMICK, *MEDICARE AND MEDICAID CLAIMS AND PROCEDURES* § 4 (1977) (overview of Part A benefits).

⁷ See 42 U.S.C.A. §§ 1395j-1395w-4(j); BUCHANAN & MINOR, *supra* note 5, at 18-19 (Part B offers broad range of benefits, including physician services and outpatient hospital services); GREENFIELD, *supra* note 2, at 9 (Part B covers services not covered under Part A); McCORMICK, *supra* note 6, § 6 (summary of Part B benefits); see also S. REP. No. 404, *supra* note 6, at 7-9, reprinted in 1965 U.S.C.C.A.N. at 1948-50 (brief summary of Part B provisions).

⁸ CONGRESSIONAL RESEARCH SERVICE, *MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS* 141 (1988) [hereinafter *SOURCE BOOK*]; see GREENFIELD, *supra* note 2, at 1 (Part A is funded by employers and employees through social security payroll taxes); see also S. REP. No. 404, *supra* note 6, at 2, reprinted in 1965 U.S.C.C.A.N. at 1943 (Part A characterized as "compulsory"); McCORMICK, *supra* note 6, § 3 (discussing of other categories of persons also covered under Medicare Part A); 1982 *MEDICARE EXPLAINED* 8 (CCH 1982) (vast majority of beneficiaries become entitled to Part A simply by virtue of eligibility for Social Security retirement or survivor benefits).

⁹ See BUCHANAN & MINOR, *supra* note 5, at 17. A monthly premium is required if the individual is not entitled to either "monthly Social Security, railroad retirement, or survivor benefits" or has not "paid Social Security payroll taxes for a certain number of quarters." *Id.*

¹⁰ See 42 U.S.C.A. § 1395f(b)(1)(A), (B) (amount paid to provider of services is reasonable cost or customary charge, whichever is less); see also S. REP. No. 404, *supra* note 6, at 6, reprinted in 1965 U.S.C.C.A.N. at 1947 ("Payment of bills under the basic plan would be made to the providers of service on the basis of the 'reasonable cost' incurred in providing care for beneficiaries.").

¹¹ *MEDICARE EXPLAINED*, *supra* note 8, at 1; see also S. REP. No. 404, *supra* note 6, at 2, reprinted in 1965 U.S.C.C.A.N. at 1943 (Part B referred to as "voluntary").

¹² See BUCHANAN & MINOR, *supra* note 5, at 18 (monthly premium in 1984 totaled \$14.60); see also S. REP. No. 404, *supra* note 6, at 7, reprinted in 1965 U.S.C.C.A.N. at 1948 (original Part B legislation called for monthly premium of \$3.00).

¹³ 42 U.S.C.A. § 1395l(a)(1).

¹⁴ See BUCHANAN & MINOR, *supra* note 5, at 19 ("Part B usually pays 80 percent of the reasonable charges of covered services, with the remaining 20 percent the responsibility of the beneficiary."). See generally GREENFIELD, *supra* note 2, at 13-14 (discussing of Part B beneficiaries' cost responsibilities).

¹⁵ In addition to the 20% coinsurance payment required of Part B insureds, both Part

While Medicare is an insurance program, Medicaid is a medical care subsidy for the poor¹⁶ and is funded jointly by the federal and state governments.¹⁷ Each state prepares its own Medicaid fee schedule which delineates a fixed cost—usually less than 80% of Medicare's "reasonable cost"—for each item or service to be covered.¹⁸ A health care provider who agrees to serve Medicaid beneficiaries must accept this fixed Medicaid fee as payment in full;¹⁹ the provider may charge neither the beneficiary nor the state for any additional amount.²⁰

Although Medicare and Medicaid are funded differently²¹ and

A and Part B patients must pay deductibles. SOURCE BOOK, *supra* note 8, at 141 ("Medicare beneficiaries are liable for cost-sharing, deductible and coinsurance payments . . ."); see also *infra* note 43 and accompanying text (brief discussion of cost-sharing). Part B deductibles, with certain exceptions, are "\$100 for 1991 and subsequent years." 42 U.S.C.A. § 1395l(b).

¹⁶ See S. REP. NO. 404, *supra* note 6, at 9, reprinted in 1965 U.S.C.C.A.N. at 1950 (Medicaid expanded prior welfare programs to cover individuals with "sufficient financial need"); see also *Harris v. McRae*, 448 U.S. 297, 301 (1980) (Medicaid provides "federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.").

¹⁷ See SOURCE BOOK, *supra* note 8, at 1-2 (states spent \$24.5 billion on Medicaid services while federal government contributed, or "matched," \$30.7 billion, for total Medicaid expenditures of \$55.2 billion); see also *id.* at 1 (Medicaid described as "Federal-State entitlement program"); GREENFIELD, *supra* note 2, at 105 ("generous federal participation in program costs" offered to participating states). Although state participation in Medicaid is optional, see 42 U.S.C.A. § 1396 (federal money is made available only to states with approved medical assistance plans), all states have taken part. See SOURCE BOOK, *supra* note 8, at 167.

As of 1988, 24.2 million persons were Medicaid beneficiaries. *Id.* at 1. Of these 24.2 million people, the three largest groups were: 1) dependent children at 10.4 million; 2) adults in families at 6.2 million; and 3) persons age 65 and over at 3.5 million. *Id.*

¹⁸ SOURCE BOOK, *supra* note 8, at 121 ("Most States have now moved to 'prospective' payment systems, under which the amount of payment [for Medicare health care providers] is established in advance."); National Senior Citizens Law Center, *States Refuse to Pay Medicare Deductibles and Co-Payments for Medicare-Medicaid Dual Eligibles*, 16 CLEARINGHOUSE REV. 129, 129 (1982) [hereinafter Law Center] (Medicaid rate usually lower than 80% of Medicare's reasonable cost).

¹⁹ See SOURCE BOOK, *supra* note 8, at 123. Although states have been granted wide latitude by the federal government to develop reimbursement schemes, three statutory constraints always apply: 1) providers must, with few exceptions, accept the Medicaid payment as payment in full; 2) Medicaid reimbursement is secondary to any other source of health coverage available to beneficiaries; and 3) payments must be "consistent with efficiency, economy, and quality of care." *Id.* (citation omitted).

²⁰ See 42 U.S.C.A. § 1320a-7b(d) (charging in excess of state plan rate is punishable by fine of not more than \$25,000 and/or imprisonment of not more than five years).

²¹ See Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 856 (1990) (Medicare financed through separate wage tax; Medicaid financed by state and federal general revenues).

administered separately,²² Medicare section 1395v²³ and its related sections²⁴ create an interplay between the two programs.²⁵ These sections permit states to enter into "buy-in" agreements with the federal government, whereby the state agency administering the Medicaid program pays Medicare Part B premiums on behalf of the state's Medicaid beneficiaries who also qualify for Medicare, i.e., people who are both poor and elderly, or "dual eligibles."²⁶ This interplay has spawned an important question of statutory interpretation, namely, whether a provider who serves dual eligibles may obtain reimbursement from the state Medicaid program for the 20% Part B coinsurance which Medicare does not reimburse. Recently, the Second Circuit in *New York City Health and Hospitals Corporation v. Perales*²⁷ ("HHC") answered this question in the affirmative.

This Comment suggests that the HHC case was incorrectly decided. Part I outlines the facts of HHC and highlights the more notable aspects of the district and appellate court decisions. Part II traces the statutory evolution of the buy-in agreement, noting conflicts and inconsistencies and suggesting that the relevant statutes are facially unclear and lack an apparent legislative direction. Finally, Part III reviews the federal agency interpretations of the

²² *Id.* ("Medicaid is jointly administered by the states and the federal government" while Medicare "is characterized by federal administration . . ."). Compare SOURCE BOOK, *supra* note 8, at 167 (states administer Medicaid programs with U.S. Department of Health and Human Services oversight) with McCORMICK, *supra* note 6, § 392, at 298 (federal government selects "fiscal intermediaries" such as Aetna Life & Casualty Co. and Blue Cross Assoc. for filing and processing Medicare beneficiaries' claims).

²³ See 42 U.S.C.A. § 1395v (titled "Agreements with States").

²⁴ See, e.g., *id.* §§ 1395v(h), 1396a(a)(10)(E), 1396a(n); see also *infra* notes 63-73 and accompanying text (full discussion of §§ 1396a(a)(10)(E) and 1396a(n)).

²⁵ See *New York City Health & Hosps. Corp. v. Perales*, No. CIV.-87-4896(MJL), 1991 WL 41559, at *5 (S.D.N.Y. Mar. 16, 1991) ("conflation . . . of statutes"); see also *infra* notes 52-84 and accompanying text (discussing of interrelationship between Medicare and Medicaid statutes).

²⁶ See SOURCE BOOK, *supra* note 8, at 141; see also Law Center, *supra* note 18, at 129 (elderly poor who are eligible for Medicare are "dual eligibles").

States have entered into buy-in agreements simply to save money. See *Congressional Budget Office Options for Reducing Medicare and Medicaid Spending*, MEDICARE AND MEDICAID GUIDE (CCH) § 37,021, at 16,398 (Mar.-Sept. 1988) ("[S]tates save roughly 75% of what would otherwise be costs for their Medicaid programs."); see also Complaint at 7, *Katz v. Myers*, CV82-1134-LTL(Tx) (C.D. Cal. dismissed Apr. 5, 1982) ("Medicare premiums, co-payments and deductibles are substantially less expensive [for the state] than the total cost of providing health services for [dual eligibles].").

²⁷ *New York City Health & Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992), *cert. denied*, 113 S.Ct. 461 (1992).

buy-in statutes, and concludes that these interpretations were permissible and worthy of the court's deference.

I. HHC FACTUAL AND PROCEDURAL SETTING

The New York Department of Social Services ("NYDSS") submitted a state Medicaid plan to,²⁸ and entered into a buy-in agreement with,²⁹ the United States Department of Health and Human Services ("Department"). Through 1986, New York's plan called for full payment of dual eligibles' Medicare Part B 20% co-insurance.³⁰ This policy was changed, however, effective January 1, 1987, with the passage of NYDSS regulation section 360-7.7,³¹ which the Department approved.³²

Section 360-7.7 was, in essence, an amendment to New York's Medicaid plan, capping the State's Part B coinsurance obligation. More specifically, the section 360-7.7 cap allowed the State not to pay coinsurance when 80% of the Medicare reasonable cost for the health care in question exceeded the Medicaid fee for the same care.³³ Unfortunately for health care providers, Medicaid fees were

²⁸ See N.Y. Soc. SERV. LAW § 363-a (McKinney 1993) (legislative directive for NYDSS to submit State Medicaid plan to federal government); see also SOURCE BOOK, *supra* note 8, at 167-68, tbl. VI-1 (all 50 states have submitted Medicaid plans).

²⁹ See SOURCE BOOK, *supra* note 8, at 142-43, tbl. IV-5 (all 50 states have entered into buy-in agreements).

³⁰ See Brief for Defendants-Appellees at 12-13, *HHC*, 954 F.2d 854 (2d Cir. 1992) (No. 91-6123) [hereinafter Defendants' Brief] ("Prior to [1987], the State authorized reimbursement for dual eligibles at full Medicare rates, including coinsurance"); accord Brief for Plaintiffs-Appellants at 2, *HHC*, 954 F.2d 854 (2d Cir. 1992) (No. 91-6123) [hereinafter Plaintiffs' Brief] ("[H]istorically, the New York Medicaid Program reimbursed providers for such cost-sharing amounts on behalf of Medicare recipients who were also Medicaid-eligible.").

³¹ N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.7(b)(1) (1992). Section 360-7.7(b)(1) reads in pertinent part that

the [Medicaid] program will pay on behalf of [Medicaid] recipients, including qualified Medicare beneficiaries, the amount of any deductible or coinsurance liability incurred under Part B of [Medicare] if the Medicare Part B payment is less than the established [Medicaid] fee. The [Medicaid] program will pay only the difference between the Medicare Part B payment and the lower of the [Medicaid] fee or the Medicare approved amount.

Id.; see also *infra* note 44 and accompanying text (brief discussion of qualified Medicare beneficiaries, or "QMBs").

³² See *HHC*, 1991 WL 41559, at *2 ("On March 16, 1988 . . . the Secretary approved . . . § 360.10"). The Court of Appeals referred to "§ 360.10" for consistency with the district court opinion, even though the section had already been repealed and recodified as § 360-7.7. See *HHC*, 954 F.2d at 855 n.1.

³³ See N.Y. COMP. CODES R. & REGS. tit. 18, § 360-7.7(b)(1); see also *HHC*, 1991 WL 41559, at *7 n.7 (three hypothetical reimbursement scenarios set forth). The following table,

typically less than 80% of Medicare reasonable costs; this meant that the State was usually not required to make any coinsurance payments.³⁴

The New York City Health and Hospitals Corporation³⁵ challenged the regulation in a suit filed in federal district court³⁶ against the Department.³⁷ Plaintiff sought, *inter alia*, to strike

adapted from figures provided in the *HHC* district court opinion, illustrates the three reimbursement scenarios:

	Scenario #1**	Scenario #2***	Scenario #3***
Medicaid Fee	\$45	\$50	\$70
Medicare Reasonable Cost*	\$80	\$60	\$60
Medicare Part B Payment Amount	\$64 (80% of \$80)	\$48 (80% of \$60)	\$48 (80% of \$60)
Medicaid Balance Due	\$0 (\$45 - \$64)	\$2 (\$50 - \$48)	\$12 (\$60 - \$48)

* The Medicare reasonable cost is also referred to as the "Medicare approved amount."

** If the Medicare payment amount exceeds the Medicaid fee, then the Medicaid program need not pay any additional amount.

*** If the Medicare payment amount is less than the Medicaid fee, the Medicaid program must pay the difference between the Medicare payment amount and the lower of the Medicaid fee and the Medicare reasonable cost.

Id. The vast majority of reimbursement situations fall within Scenario #1. *See infra* note 34.

The following is another reimbursement example: "[T]he Medicare allowable charge for a particular service is \$100 [and] Medicare pays \$80, leaving \$20 to be paid as coinsurance. If the State's fee limit for the same service is \$75, the State may conclude that the [provider] has already been paid in full." SOURCE BOOK, *supra* note 8, at 145.

³⁴ See *HHC*, 954 F.2d at 857 ("Medicaid payments are almost invariably less than 80% . . ."). By one estimate, the § 360-7.7 payment limit saved New York's Medicaid program as much as \$53 million in 1987. See Jeannie H. Cross, *Social Services Cuts Medicaid Payments*, TIMES UNION (Albany), July 17, 1987, at B5. A significant portion of the State savings has been absorbed by organizations like the Health and Hospitals Corporation, which allegedly has lost \$6 million per year since the regulation was passed. See Deborah Pines, *N.Y. Court Restores Supplemental Payment for Medicare Patients*, NAT'L L. J., Feb. 17, 1992, at 54.

³⁵ See *HHC*, 954 F.2d at 855 (*HHC* described as "principal provider of hospital services to the low-income population of [New York] City"). The other *HHC* plaintiffs included the Medical Society of the State of New York, a voluntary association of New York doctors, and Sidney Finkel and John Bleski, two doctors who treat patients eligible for both Medicare and Medicaid. *Id.*

³⁶ *New York City Health & Hosps. Corp. v. Perales*, No. CIV. 87-4896(MJL), 1991 WL 41559 (S.D.N.Y. Mar. 16, 1991).

³⁷ *Id.*; see also *HHC*, 954 F.2d at 855 (plaintiffs named Department Secretary Louis W. Sullivan and NYDSS Commissioner Cesar A. Perales as defendants). Commissioner Perales,

down the regulation because it allegedly violated the statutory right of health care providers to recover 100% of their Medicare reasonable cost.³⁸ After deciding that the statutes involved were “complicated, ambiguous, and often apparently conflicting,”³⁹ and that the Department’s interpretation was permissible,⁴⁰ the district court granted defendant’s motion for summary judgment.

The Second Circuit reversed and entered summary judgment in favor of plaintiff,⁴¹ declaring that the Department’s interpretation was contrary to the clear congressional mandate and was therefore not entitled to deference.⁴² Writing for the court, Judge Feinberg explained that the language of Medicaid section

however, “concur[red] with the views of [Department Secretary] Sullivan” and did not file a separate brief. *Id.*

³⁸ See *HHC*, 1991 WL 41559, at *1-2. “Specifically, plaintiffs contend that § [360-7.7]: 1) deprives providers . . . reimbursement of their reasonable costs . . . in violation of the Medicare Act (Count I); 2) violates the Medicare Act’s prohibition of cost-shifting (Count II); [and] 3) violates specified portions of the Medicaid Act’s crossover provisions (Count III). . . .” *Id.* at *2. Although plaintiffs asserted that the State and the beneficiaries were liable for reimbursement of reasonable costs, according to the court “[t]he real target of plaintiffs’ claims . . . [was] not the beneficiary, but the state and its Medicaid plan.” *Id.* at *5. This same focus on the State’s rather than the beneficiaries’ obligations was evident at the appellate level. See *HHC*, 954 F.2d at 857-58 (“[W]e must determine what *New York State’s responsibility* is . . . for . . . 20% of reasonable costs”) (emphasis added); *id.* at 867 (Cardamone, J., dissenting) (issue presented is whether “providers must be reimbursed by the state”) (emphasis added).

³⁹ *HHC*, 1991 WL 41559, at *6.

⁴⁰ *Id.* “[W]hile other interpretations may also be rational, it would not be appropriate for this Court to overturn defendants’ rational policy.” *Id.*

Other grounds for granting defendants’ motion were advanced by the district court, but are not the focus of this Comment. These grounds include, for example, Medicaid as a third party payor. See *id.* at *4. See generally SOURCE BOOK, *supra* note 8, at 141 (“Medicaid is the payor of last resort, secondary to any other insurance coverage a beneficiary may have or to any other third party who may be liable for medical payments or medical support on the beneficiary’s behalf.”). Also beyond the scope of this Comment is any attempt to reconcile the competing policy underpinnings of Medicare and Medicaid. See generally *HHC*, 1991 WL 41559, at *5 (discussion of statutes’ underlying policies vis-a-vis beneficiaries and providers); RANDALL R. BOVBERG & JOHN HOLAHAN, MEDICAID IN THE REAGAN ERA 17 (1982) (“How generous to recipients and providers a Medicaid program is designed to be varies with the state’s political philosophy and wealth.”).

⁴¹ *HHC*, 954 F.2d at 855-56.

⁴² See *id.* at 863.

Sometimes we will find that Congress has not addressed the problem posed by a particular case. In such circumstances, we are required to defer to administrative expertise. But where we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer.

Id.

1396a(a)(10)(E)(i) directed states to pay Part B cost-sharing⁴³ on behalf of dual eligibles and on behalf of those elderly who were too poor to afford Part B cost-sharing, but not poor enough to qualify for Medicaid ("qualified Medicare beneficiaries" or "QMBs").⁴⁴ In reviewing the legislative history, the court stated that it was Medicare's policy to allow health care providers recovery of 100% of reasonable costs.⁴⁵ To hold otherwise, according to the court, would create a "wealth based, two-tiered system of health care" that Congress specifically sought to avoid,⁴⁶ i.e., a provider would

⁴³ See 42 U.S.C.A. § 1396d(p)(3) (cost-sharing defined as including premiums, deductibles, and coinsurance).

⁴⁴ See *HHC*, 954 F.2d at 859 ("apparent meaning" of § 1396a(a)(10)(E) was to direct states to allocate funds for Part B premiums, deductibles, and coinsurance); see also 42 U.S.C.A. § 1396d(p)(1) (QMB definition).

In order for an individual to qualify as a QMB, three requirements must be satisfied. First, a person must be entitled to Medicare Part A. *Id.* at § 1396d(p)(1)(A). Second, he or she must have income not exceeding the official federal poverty line as determined under the supplemental security income program. *Id.* at § 1396d(p)(1)(B). Finally, the individual must not have resources exceeding twice the maximum amount allowed under the same program. *Id.* at § 1396d(p)(1)(C).

Originally, states were permitted to buy-in only on behalf of persons eligible for both Medicare and Medicaid, i.e., dual eligibles. See SOURCE BOOK, *supra* note 8, at 141-42 (describing pre-1986 buy-in requirements). In 1986, however, Congress, concerned about individuals not poor enough to qualify for Medicaid and too poor to afford Part B cost-sharing, permitted states to buy-in for this new category of elderly which were designated QMBs. See H.R. REP. NO. 727, 99th Cong., 2d Sess. 105 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3695 ("The Committee strongly encourages States to expand Medicaid coverage to additional low-income elderly . . ."); see also H.R. REP. NO. 105(II), 100th Cong., 2d Sess. 57-8 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 880-81 (in 1986, only 1.1 million of 3.3 million elderly poor were entitled to Medicaid). See generally SOURCE BOOK, *supra* note 8, at 143 (discussing states' option to cover QMBs).

At first, QMBs and dual eligibles were separate and distinct groups of beneficiaries, the former only eligible for Medicare while the latter eligible for both. See Omnibus Reconciliation Act of 1986, Pub. L. No. 99-509, § 9403(b), 100 Stat. 1874, 2053-4 (1986) (QMB "means an individual who is entitled to . . . part A [but is] not eligible for [Medicaid]"). Now, the QMB definition subsumes dual eligibles. See 42 U.S.C.A. § 1396d(p)(1) (current QMB definition). In *HHC*, the Second Circuit seemed to refer to QMBs and dual eligibles interchangeably. See, e.g., *HHC*, 954 F.2d at 857-58 ("We must determine what New York State's responsibility is . . . for the annual deductible and 20% of reasonable costs . . . for patients who are *dual eligibles or QMBs*.") (emphasis added).

⁴⁵ *HHC*, 954 F.2d at 858. The court repeated this 100% reimbursement theme throughout its opinion. See, e.g., *id.* ("[T]here is nowhere articulated in the Medicare Act or regulations an exception for dual eligibles or QMBs or any limitation on providers' express statutory right to recover their full reasonable costs . . ."); *id.* ("Medicare Act on its face entitles providers to collect their reasonable costs"); *id.* at 860 ("Medicare provider need not be satisfied with inadequate payment, i.e., less than reasonable costs"); *id.* at 861 ("guarantee of reimbursement").

⁴⁶ *Id.* at 859.

be less likely to treat a patient if full payment was not assured.⁴⁷ Finally, Judge Feinberg noted in dicta that even if the statutes were unclear, the usual deference given to administrative agencies would not have constrained the court because the Department's own inconsistent policy statements eroded the integrity of its position.⁴⁸

Dissenting, Judge Cardamone criticized the court's premise that the statutes specifically addressed the issue at hand.⁴⁹ The appropriate inquiry, according to the dissent, was not whether the statute expressly allowed providers to recover coinsurance, but whether the responsible agency's interpretation was contrary to congressional purposes.⁵⁰ Furthermore, Judge Cardamone noted that Department policy revisions promulgated subsequent to the enactment of the statutes were not arbitrary, but occasioned by changed circumstances and case law.⁵¹

II. CLEAR CONGRESSIONAL INTENT? STATUTORY EVOLUTION OF BUY-IN AGREEMENT FROM 1965 TO PRESENT

A. Social Security Amendments of 1965

Although repealed in 1988, Medicaid section 1396a(a)(15), part of the 1965 Medicaid legislation,⁵² dealt with the coinsurance

⁴⁷ See *id.* (hospitals would be deterred from serving nonpaying or underpaying patients) (citing S. REP. NO. 404, *supra* note 6, at 27, reprinted in 1965 U.S.C.C.A.N. at 1967-68).

⁴⁸ *Id.* at 861-62 ("The expertise in statutory interpretation to which we normally defer becomes dubious when the expert cannot make up his own mind.").

⁴⁹ *Id.* at 864 (Cardamone, J., dissenting) ("Nothing in the language of these Acts . . . fairly supports an inference that Congress *specifically* intended crossover and QMB Part B service providers to be reimbursed at the Medicare reasonable cost/charge level.") (emphasis in original); see also *id.* (statute "simply does not lay out a 'clear' plan of Congress contrary to the Secretary's construction") (emphasis in original); *id.* (statutes described as "ambiguous and conflicting").

⁵⁰ *Id.* at 863-64 (citing *United States v. City of Fulton*, 475 U.S. 657, 666 (1986)).

⁵¹ *Id.* at 867 (more important than agency's change of policy itself is "whether the agency's change . . . rests on a 'well-considered basis'") (citing *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 355-56 (1989)).

⁵² 42 U.S.C.A. § 1396a(a)(15), *repealed by* Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(e)(2)(C), *as added by* Family Support Act of 1988, Pub. L. No. 100-485, § 608(d)(14)(I)(iii), 102 Stat. 2343, 2416 (1988). From 1967 until its repeal in 1988, § 1396a(a)(15) said that a state Medicaid plan must

in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by title XVIII, provide where, under the plan, all of any deductible, cost sharing, or similar charge im-

obligations of states when the states chose to enter into buy-in agreements.⁵³ Regrettably, the section was ambiguously worded.⁵⁴ Prior to its repeal, two federal district court decisions—*James v. Morris*⁵⁵ and *Samuel v. California Department of Health Services*⁵⁶—each attempted to extract a sensible meaning from the section.⁵⁷ Both courts concluded that the state Medicaid programs could pay, at their discretion, *part or all* of dual eligibles' cost-sharing charges.⁵⁸

Although more plainly worded than the statute, the legislative history accompanying section 1396a(a)(15)⁵⁹ seems similarly un-

posed with respect to such individual under the insurance program established by such title is not met, the portion thereof which is met shall be determined on a basis reasonably related . . . to such individual's income or his income and resources.

Social Security Amendments of 1967, Pub L. No. 90-248, § 235(a)(3), 81 Stat. 821, 1031 (1967) (amending § 1396a(a)(15) of Social Security Amendments of 1965).

⁵³ See *HHC*, 954 F.2d at 860 (analyzing § 1396a(a)(15) as guide for understanding section that replaced it). Although § 1396a(a)(15) is no longer in effect, *HHC* plaintiffs and defendants referred to the section repeatedly in an effort to glean Congress' intent with respect to buy-in agreements. See Plaintiffs' Brief, *supra* note 30, *passim*; Defendants' Brief, *supra* note 30, *passim*.

⁵⁴ See *supra* note 52 (pertinent portion of § 1396a(a)(15) set out); see also *infra* note 57 (noting two federal district courts' characterizations of § 1396a(a)(15)'s unfortunate wording).

⁵⁵ Civ. Action No. 80-172-N (M.D. Ala., N. Div., Apr. 29, 1981) (unreported case); see also Final Regulations on Buy-ins, Quality Control, Laboratory Animals, and Abortions, MEDICARE AND MEDICAID GUIDE (CCH) § 36,762, at 15,777 (Sept. 1987-Mar. 1988) (noting that copies of *Morris* are available from Health Care Financing Administration, an arm of United States Department of Health and Human Services).

⁵⁶ 570 F. Supp. 566 (N.D. Cal. 1983), as amended by 572 F. Supp. 273 (N.D. Cal. 1983).

⁵⁷ See *id.* at 570 (legislative intent behind § 1396a(a)(15) with respect to level of health care provider reimbursement was "unclear"); *Morris*, Civ. Action No. 80-172-N, at 3 (noting § 1396a(a)(15)'s "bewildering language").

⁵⁸ See *Samuel*, 570 F. Supp. at 570 n.2 ("[H]ad the statute required a State plan to relate the *unmet* portion of Medicare Part B deductible and coinsurance costs to a beneficiary's income, the statute would then have effectively required the State to meet whatever costs a beneficiary could not pay.") (emphasis in original); *Morris*, Civ. Action No. 80-172-N, at 3 (state may "choose[] to meet a portion, but not all, of the cost-sharing charges"); cf. *American Medical Ass'n v. Matthews*, 429 F. Supp. 1179, 1195 (N.D. Ill. 1977) (noting that legislative history behind Medicaid program indicated Congressional intent was "to encourage and preserve a wide measure of state autonomy . . . in the determination of the reasonable costs of Medicaid programs").

⁵⁹ S. REP. NO. 404, *supra* note 6, at 79-80, reprinted in 1965 U.S.C.C.A.N. at 2020.

A State [Medicaid] plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's [ability to pay].

Id.

clear. The *Samuel* court, for instance, reviewed pertinent segments of the history and came to the conclusion that the state was not obligated to pay coinsurance.⁶⁰ In addition, a key clause of the legislative history to section 1396a(a)(15) explained that a "State [Medicaid] plan *may provide for the payment in full*."⁶¹ It is submitted that this language can reasonably be interpreted to mean that a state may also pay less than the full coinsurance amount.⁶²

B. OBRA 1986

There was no additional significant legislation regarding buy-in agreements until the passage of the Omnibus Budget Reconciliation Act of 1986 ("OBRA 1986"),⁶³ which added two sections to the Social Security Act pertinent to buy-in agreements: 1396a(a)(10)(E)⁶⁴ and 1396a(n).⁶⁵ The former gave states the option to enter into buy-in agreements for QMBs.⁶⁶ Under 1396a(a)(10)(E)(i), once a state elects to cover QMBs, it "must" pay Part B cost-sharing.⁶⁷ Since the definition of cost-sharing included coinsurance,⁶⁸ this section seemed to support the argument that health care providers should recover the 20% not covered by

⁶⁰ Compare *Samuel*, 570 F. Supp. at 570-71 (Medicaid legislative history *does not guarantee* provider full payment, but *protects beneficiary* from cost-sharing responsibilities beyond his or her means) with *HHC*, 954 F.2d at 860-61 (disagreeing with *Samuel* and "includ[ing] in any examination of [Medicaid] legislative history an examination of the history of the Medicare Act").

⁶¹ S. REP. No. 404, *supra* note 6, at 79, *reprinted in* 1965 U.S.C.C.A.N. at 2020 (emphasis added).

⁶² Unfortunately, review of the legislative history's "Section-by-Section Analysis" sheds no additional light on the matter. See S. REP. No. 404, *supra* note 6, at 177-78, *reprinted in* 1965 U.S.C.C.A.N. at 2117-18 ("Section-by-Section Analysis" subpart relating to buy-in agreements).

⁶³ Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053-56 (1986).

⁶⁴ *Id.* § 9403(a)(3) (codified as 42 U.S.C.A. § 1396a(a)(10)(E)). A state plan for Medicaid must provide, "at the option of a State, . . . for making medical assistance available for medicare cost-sharing . . . for qualified medicare beneficiaries." *Id.*

⁶⁵ *Id.* § 9403(e) (codified as 42 U.S.C.A. § 1396a(n)) (titled "Payment amounts"). "[T]he State [Medicaid] plan may provide payment in an amount . . . exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals." *Id.*

⁶⁶ See H.R. REP. No. 727, *supra* note 44, at 106, *reprinted in* 1986 U.S.C.C.A.N. at 3696 ("Committee hopes States with constrained resources will consider pursuing this option as a first step to more comprehensive coverage"); see also *supra* note 44 (QMB discussion).

⁶⁷ 42 U.S.C.A. § 1396a(a)(10)(E)(i).

⁶⁸ *Id.* § 1396d(p)(3) (cost-sharing includes premiums, deductibles, and 20% coinsurance).

Medicare.⁶⁹ Moreover, part of the OBRA 1986 legislative history buttressed this interpretation: "For [the] elderly . . . whom the State chose to cover, the Medicaid program would pay for the Part B deductible and the beneficiary's 20 percent coinsurance on Part B services."⁷⁰

However, the second OBRA 1986 buy-in section noted above—1396a(n), titled "Payment amounts"—was less favorable to health care providers.⁷¹ With regard to QMBs, section 1396a(n) provided that the Medicaid payment plus the Medicare payment "may" exceed the Medicaid rate for the item or service in question.⁷² The use of "must" in section 1396a(a)(10)(E)(i) and the use of "may" in section 1396a(n) are difficult to reconcile, and this conflict further evidences the ambiguity and inconsistencies in the Medicaid statute.⁷³

C. MCCA 1988

Soon after the enactment of OBRA 1986, the Medicare Catastrophic Coverage Act of 1988 ("MCCA 1988") was passed.⁷⁴ MCCA 1988 included two significant modifications to the then existing buy-in law. First, MCCA 1988 excised the option language

⁶⁹ See Patricia Nemore, *Changes in OBRA-90 Affecting Medicaid Eligibility and Services for the Elderly and Disabled*, 24 CLEARINGHOUSE REV. 1362, 1362 (1991) (noting Department's interpretation, but proposing that state responsibility for 20% coinsurance was "challengeable under provisions of the law defining 'cost-sharing'").

⁷⁰ H.R. REP. NO. 727, *supra* note 44, at 106, *reprinted in* 1986 U.S.C.C.A.N. at 3696.

⁷¹ See *supra* note 65 (pertinent part of § 1396a(n) set out).

⁷² See *supra* note 65 (§ 1396a(n) "may" language set out); see also H.R. CONF. REP. NO. 1012, 99th Cong., 2d Sess. 395-96 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3868, 4040-41 ("total of Medicaid payments for Medicare cost sharing . . . together with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services") (emphasis added).

⁷³ In addition to the "must" versus "may" conflict, § 1396a(a)(10)(F)(II) contains a "part or all" clause which, it is submitted, can reasonably be construed to clash with the combined language of §§ 1396a(a)(10)(E)(i) and 1396d(p)(3), creating an additional ambiguity. See *supra* notes 68-69 and accompanying text (arguing that reading of §§ 1396a(a)(10)(E)(i) and 1396d(p)(3) together militates in favor of full provider reimbursement). Section 1396(a)(10)(F)(II) provides that

the making available of supplementary medical insurance benefits under part B of [Medicare] to individuals eligible therefor . . . or provision for meeting *part or all* of the cost of deductibles, cost sharing, or similar charges under part B of [Medicare] . . . shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals

⁷⁴ U.S.C.A. § 1396a(a)(10)(F)(II) (emphasis added).

⁷⁵ Pub. L. No. 100-360, 102 Stat. 683 (1988).

from section 1396a(a)(10)(E), thereby making QMB buy-ins mandatory.⁷⁵ Second, MCCA 1988 deleted section 1396a(a)(15).⁷⁶ The full import of these changes, however, is not easily discerned, especially when analyzed within the context of the confusing and contradictory legislative history.

For example, the House Report seemed to support the providers' position by noting that "[s]tates would be required to pay the Medicare premiums, deductibles, and coinsurance for all elderly [who met income and resource requirements]."⁷⁷ This notion was repeated in a subsequent passage of the same report.⁷⁸ Moreover, the House Conference Report further solidified the notion of full provider reimbursement.⁷⁹ However, a hypothetical reimbursement scenario included in the House Report seemed to support the argument that, at least in certain situations, states were not required to pay more than their plan's Medicaid fee.⁸⁰

D. OBRA 1989

If it can be said that most of the MCCA 1988 legislative history supported plaintiff's position in *HHC*, then it may likewise be suggested that the bulk of the Omnibus Budget Reconciliation Act of 1989 ("OBRA 1989") legislative history supported defendant's position. The House Report accompanying OBRA 1989, for exam-

⁷⁵ See *id.* at §301(a)(1) (1988) (deletion of option language); 42 U.S.C.A. § 1396a(a)(10)(E)(i) (current statute reflecting deletion).

⁷⁶ 42 U.S.C.A. § 1396a(a)(15), *repealed by* Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(e)(2)(C), *as added by* Family Support Act of 1988, Pub. L. No. 100-485, § 608(d)(14)(I)(iii), 102 Stat. 2343, 2416 (1988).

⁷⁷ See H.R. REP. NO. 105(II), *supra* note 44, at 60, *reprinted in* 1988 U.S.C.C.A.N. at 883.

⁷⁸ See H.R. REP. NO. 105(II), *supra* note 44, at 61, *reprinted in* 1988 U.S.C.C.A.N. at 884. "The bill would require States to pay Medicare cost-sharing, including coinsurance [sic], on behalf of eligible individuals." *Id.*

⁷⁹ See H.R. CONF. REP. NO. 661, 100th Cong., 2d Sess. 253 (1988), *reprinted in* 1988 U.S.C.C.A.N. 923, 1031 ("[m]akes mandatory the current option for States to pay Medicare premiums, deductibles and coinsurance").

⁸⁰ See H.R. REP. NO. 105(II), *supra* note 44, at 61, *reprinted in* 1988 U.S.C.C.A.N. at 884.

For example, assume that a physician actually charges a "buy-in" patient \$60 for performing a particular procedure; that Medicare recognizes \$50 as the reasonable charge; and that the State Medicaid program only pays \$35 for this procedure. . . . Medicare will pay only 80 percent of \$50, leaving a \$10 coinsurance obligation for the beneficiary. However, since the State only recognizes \$35 as the fee for the procedure in question, and since the Medicare program has already paid the physician \$40, the State is not required to pay any of the \$10 coinsurance.

Id.

ple, stated that "Medicaid programs typically pay the Medicare co-insurance *only to the extent* that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question."⁸¹ In addition, the report concluded that the proposed bill was not intended to alter the current practice by the states of capping Part B coinsurance payments at the Medicaid rate.⁸²

E. Summary of Statutory Evolution

Congress enacted four pieces of legislation related to buy-in agreements.⁸³ When viewed as a whole, it is suggested that the laws did not communicate a clear legislative mandate regarding state liability for coinsurance.⁸⁴ In light of this, the *HHC* court should have given deference to the Department's interpretation, provided that the interpretation was permissible. Whether the interpretation was permissible is explored in Part III.

III. IMPERMISSIBLE AGENCY INTERPRETATION? DEPARTMENT'S INTERPRETATION OF BUY-IN LAW FROM 1971 TO PRESENT

A. 1971 Department Policy

A 1971 Department internal memorandum titled "Policy In-

⁸¹ H.R. REP. No. 247, 101st Cong., 1st Sess. 364 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2090 (emphasis added). *But see HHC*, 954 F.2d at 861 (court discounted weight of "subsequent legislative history").

⁸² *See* H.R. REP. No. 247, *supra* note 81, at 364, *reprinted in* 1989 U.S.C.C.A.N. at 2090 (proposed legislation regarding physicians' services "does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims").

⁸³ *See supra* notes 52-82 and accompanying text (discussing conflicts within Medicare and Medicaid statutes and legislative histories).

⁸⁴ *See generally* Kinney, *supra* note 21, at 864-65 ("eligibility requirements for the Medicaid program are complex and . . . byzantine"). "Since Medicaid's inception, Congress has repeatedly changed eligibility requirements to address specific needs. The result . . . is a highly technical, virtually incomprehensible body of Medicaid eligibility law." *Id.* at 864-65 (footnote omitted).

Indeed, federal courts have set forth colorful characterizations of the Social Security Act in general, and these characterizations seem applicable to the portions of the Act relative to buy-ins. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (characterizing Social Security Act as "Byzantine"); *Friedman v. Berger*, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976), *aff'd*, 547 F.2d 724 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977) (describing Medicaid statute as "an aggravated assault on the English language"); *id.* (depicting statute as "murky" and as "poor example to those who would like to use plain and simple expressions").

formation Memo No. 6" seems to represent the agency's initial position with respect to buy-in coinsurance reimbursement.⁸⁵ Of most importance to the *HHC* case, paragraph 5 of the memorandum declared that a state must pay "only that amount which will satisfy the requirement for payment in full *according to the [Medicaid] method of payment.*"⁸⁶ Paragraph 2 of the same memorandum, however, explained that "[a] state may not limit its payment of deductibles and co-insurance to those services provided by Part B benefits that are otherwise included in the [Medicaid] plans."⁸⁷

B. 1981 Morris Case

An Alabama federal district court in *James v. Morris* appears to be the first to adjudicate a claim relative to coinsurance reimbursement.⁸⁸ Although the court did not specifically refer to any Department policy, its decision was consistent with paragraph 5 of Memo No. 6.⁸⁹ According to the court, Alabama's Medicaid plan called for the State to pay "*all or part* of the cost of the deductible [and] cost-sharing . . . under Part B."⁹⁰ The *Morris* court first concluded that the "all or part" language did not violate federal buy-in statutes.⁹¹ The court then held that Alabama was "not required to pay the cost-sharing charges for health care services which [were] not covered in the [Medicaid] Plan."⁹² Thus, paragraph 5 of the Department's Memo No. 6 was tacitly affirmed and paragraph 2 was rejected.⁹³

⁸⁵ See Joint Appendix at 75, *HHC*, 954 F.2d 854 (2d Cir. 1992) (No. 91-6123).

⁸⁶ *Id.* at para. 5 (emphasis added).

⁸⁷ *Id.* at para. 2 ("When a State agency enters into a buy-in agreement[,] all the benefits under Part B become part of the State plan for individuals covered under the agreement."). The following example is submitted to help illustrate: if Medicare Part B covered Procedures X and Y, and if a given state's Medicaid program covered Procedures Y and Z, then the state may not, according to paragraph 2 of Memo No. 6, limit its payment of deductibles and coinsurance only to Procedure Y. By implication, the state must pay deductibles and coinsurance for Procedure X.

⁸⁸ *James v. Morris*, Civ. Action No. 80-172-N (M.D. Ala., N. Div., Apr. 29, 1981).

⁸⁹ See *supra* text accompanying notes 85-86 (discussing paragraph 5 of Department's Memo No. 6).

⁹⁰ *Morris*, Civ. Action No. 80-172-N, at 2 (emphasis added).

⁹¹ *Id.* at 3 ("[Section 1396a(a)(15)] does not . . . mandate that a portion of the cost-sharing charges be met.").

⁹² *Id.* at cover page. This portion of the *Morris* holding impliedly disaffirmed the less important paragraph 2 of Memo No. 6. See *supra* note 87 and accompanying text (discussing paragraph 2).

⁹³ Regarding post-*Morris* developments relative to paragraph 2, see, e.g., MEDICARE AND MEDICAID GUIDE, *supra* note 55, at 15,777 (discussing Department's final rule recognizing

C. 1981 Reiteration of 1971 Department Policy

The next policy announcement by the Department was the 1981 "Policy Information for All Regions" memorandum published by the Department Director, Bureau of Program Policy, five months after *Morris* was decided.⁹⁴ This memorandum reiterated the 1971 policy statement regarding the Medicaid rate cap.⁹⁵

In the same memorandum, the Director addressed a special provider billing arrangement that allowed a provider that had not been paid by a state Medicaid agency to collect from the patient in certain circumstances.⁹⁶ The *HHC* defendant conceded that this arrangement was correctly stricken by a federal district court in *Samuel v. California Department of Health Services*.⁹⁷ The *HHC* court seized on this concession and the *Samuel* court ruling as a dramatic policy shift that was significant to the instant question of whether the Department's statutory interpretation should be accorded deference.⁹⁸ However, it is submitted that this billing arrangement was not pertinent to the issue before the *HHC* court, i.e., the *State's* obligation to pay Part B coinsurance was the question in *HHC*, not the *patient's* obligation when the provider did not bill the Medicaid program at all.⁹⁹ Therefore, even if Department policy was inconsistent, the inconsistency had no bearing on

and codifying *Morris* case with respect to non-covered services). See generally *infra* notes 101-107 and accompanying text (discussion of Department's 1983 and 1988 proposed and final rules).

⁹⁴ See Joint Appendix, *supra* note 85, at 74 (Department memorandum dated September 29, 1981, from Peter Bouxsein, Bureau of Program Policy, to Associate Regional Administrator, Division of Program Operations, Region IX).

⁹⁵ See *id.* (referring to "longstanding policy" originally announced in paragraph 5 of 1971 Memo No. 6).

⁹⁶ See *id.* (arrangement provided that "[i]f the [state Medicaid] agency ha[d] made no payment at all, the physician/supplier may collect coinsurance and deductibles from the [Medicaid] eligible patient").

⁹⁷ 570 F. Supp. 566, 573 (N.D. Cal. 1983), as amended by 572 F. Supp. 273 (N.D. Cal. 1983) ("[c]ourt disagrees with the State interpretation" that dual eligibles may be charged for cost-sharing); Plaintiffs' Brief, *supra* note 30, at 29 n.* (acknowledging that policy regarding beneficiary liability was correctly stricken by *Samuel* court).

⁹⁸ See *HHC*, 954 F.2d at 861-62 ("expertise in statutory interpretation to which we normally defer becomes dubious when the expert cannot make up his own mind").

⁹⁹ Compare Joint Appendix, *supra* note 85, at 74 (1981 Department memo) (If Medicaid "has made no payment at all, the physician/supplier may collect coinsurance and deductibles from the [Medicaid] eligible patient.") (emphasis added) with *HHC*, 954 F.2d at 857-58 ("we must determine what *New York State's* responsibility is . . . for . . . 20% of reasonable costs") (emphasis added); see also *HHC*, 1991 WL 41559, at *5 ("real target of plaintiffs' claims . . . is not the beneficiary, but the state and its Medicaid plan").

the *HHC* case.¹⁰⁰

D. 1983 and 1988: Proposed and Final Rules in Response to Morris Case

In March 1983, the Department proposed new regulations to adopt the *Morris* holding, requiring only optional state cost-sharing responsibility for Medicare Part B services not covered in the state Medicaid plan.¹⁰¹ This proposed rule became final in 1987 and effective in January 1988.¹⁰² In addition to codifying this portion of *Morris*, the narrative accompanying the final rule responded to various commentators' questions with respect to buy-in reimbursement requirements.¹⁰³ One question was "whether States had the option to limit payment of Part B cost sharing amounts in accordance with state limitations imposed on Medicaid services covered under the state plan."¹⁰⁴ The Department's answer was "[y]es."¹⁰⁵ It is submitted that this affirmative response was reasonable and consistent with paragraph 5 of the Department's 1971 Memo No. 6¹⁰⁶ and with the Department's policy announcement of 1981.¹⁰⁷

E. Summary of Agency Interpretation

The Medicare buy-in legislation is conflicting and ambiguous.¹⁰⁸ Because of this profound disarray in the law, it is submitted

¹⁰⁰ Cf. *HHC*, 954 F.2d at 867-68 (Cardamone, J., dissenting) ("What is more important [than inconsistency] is whether the agency's change in position rests on a 'well-considered basis'.") (citing *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 355-56 (1989)).

¹⁰¹ See Proposed Rule, Medicaid Program, Relation With Other Agencies, and Miscellaneous Medicaid Definitions, 48 Fed. Reg. 10,378 (1983) (codified at 42 C.F.R. § 431.625) (proposed Mar. 11, 1983) [hereinafter 1983 NPRM]. The *James v. Morris* case discussed in Part II, Subpart B of this Comment was incorrectly referred to as *James v. Harris* in the 1983 NPRM. See Final Rule, Medicaid Program; Relations With Other Agencies, Miscellaneous Medicaid Definitions, Third Party Liability Quality Control, and Limitations on Federal Funds for Abortions, 52 Fed. Reg. 47,926 (1987) (codified at 42 C.F.R. § 431.625) (corrected at 53 Fed. Reg. 657) (effective Jan. 18, 1988) [hereinafter 1988 Final Rule].

¹⁰² See 1988 Final Rule, *supra* note 101.

¹⁰³ *Id.* (29 commentators posed questions based on 1983 NPRM; Department grouped similar questions and published 12 comments and responses).

¹⁰⁴ *Id.* (comment 8).

¹⁰⁵ *Id.* (response to comment 8).

¹⁰⁶ See *supra* text accompanying note 86 (quoting pertinent portion of paragraph 5).

¹⁰⁷ See *supra* notes 94-95 and accompanying text (noting 1981 Department reiteration of 1971 policy).

¹⁰⁸ See *supra* notes 52-84 and accompanying text (discussing of conflicting and inconsistent buy-in statutes).

that alternative regulatory positions were permissible, and that one of these possible positions was the Department's.¹⁰⁹ Because the Department's interpretation was reasonable,¹¹⁰ the court in *HHC* should not have intervened.¹¹¹

¹⁰⁹ See *supra* note 58 and accompanying text (*Morris* and *Samuel* decisions regarding discretionary nature of states' cost-sharing obligations support Department's position); *supra* notes 61-62 and accompanying text ("may" terminology in § 1396a(a)(15) legislative history supports Department's position); *supra* notes 71-72 and accompanying text ("may" language in § 1396a(n) supports Department's position); *supra* note 80 and accompanying text (explanation of Medicaid cap in MCCA 1988 legislative history supports Department's position); *supra* note 81-82 and accompanying text (explanation of Medicaid cap in OBRA 1989 legislative history supports Department's position); see also *Chevron U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984) ("[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.") (footnote omitted); *id.* at 843 n.11 ("court need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction"); *Federal Election Comm'n v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 39 (1981) (to uphold regulation "it is not necessary for a court to find that the agency's construction was the only reasonable one or even the reading the court would have reached if the question initially had arisen in a judicial proceeding") (footnote omitted). But see *HHC*, 1991 WL 41559, at *5 (court did "not mean to suggest that [health care providers'] position with respect [to] the buy-in agreements [was] wholly unsupportable").

Agency regulations, like the NYDSS regulation at issue in *HHC*, control unless they are: 1) "arbitrary," 2) "capricious," or 3) "manifestly contrary to the statute." *Chevron*, 467 U.S. at 844. The Department's consistent and reasonable policy with respect to the states' co-insurance obligations, it is suggested, seems to be well within the generous latitude provided to agencies by *Chevron*. See generally Robert A. Anthony, *Which Agency Interpretations Should Bind Citizens and the Courts?*, 7 YALE J. ON REG. 1, 3 (1990) ("law governing judicial acceptance of agencies' interpretations of the statutes they administer is now dominated by *Chevron*"). Even assuming arguendo that the Department's policy revision with respect to non-covered Part B services was pertinent to the *HHC* case, see *supra* note 99 and accompanying text (suggesting that New York's obligations, not patients', were in issue), it is submitted that this revision in and of itself was not grounds for not deferring to the agency interpretation. See Anthony, *supra*, at 27 ("agency may change its view, provided the new interpretation is consistent with statute and reasonable, and the change was based on reasoned decisionmaking, adequately explained") (citing *Chevron*, 467 U.S. at 863-64).

¹¹⁰ See text accompanying notes 104-107 (suggesting that Department's 1988 Final Rule and accompanying narrative was reasonable construction of buy-in statutes and consistent with Department policy pronouncements of 1971 and 1981).

¹¹¹ See *National R.R. Passenger Corp. v. Boston & Me. Corp.*, 112 S.Ct. 1394, 1401 (1992) ("Judicial deference to reasonable interpretations by an agency of a statute that it administers is a dominant, well settled principle of federal law."); *United States v. City of Fulton*, 475 U.S. 657, 666 (1986) ("We must uphold [the agency's] interpretation if the statute yields up no definitive contrary legislative command and if the [agency's] approach is a reasonable one.") (citing *Chevron*, 467 U.S. at 842-45).

The Department, arguably, has been accorded even greater deference in cases involving construction of the Social Security Act. See, e.g., *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) ("Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary *exceptionally broad authority* to prescribe standards for applying certain sections of the Act.") (citing *Batterton v. Francis*, 432 U.S. 416, 425 (1977)) (emphasis

CONCLUSION

The statutes and legislative history pertaining to Medicare Part B buy-in agreements are unclear, and the interpretation of the responsible federal agency was permissible. The agency interpretation, therefore, should have been accorded deference by the Second Circuit, and the regulation in issue should not have been invalidated. It is hoped that the arguments advanced in this Comment will help spur Congress to clarify the buy-in law and will assist present and prospective litigants in jurisdictions outside New York who seek outcomes different than the one in *HHC*.¹¹²

Christopher P. Parnagian

EDITOR'S NOTE

On the eve of this Comment's publication, a federal district court in Alabama decided *Haynes Ambulance Service, Inc. v. Alabama*, No. CIV.A.92-H-879-N, 1993 WL 147940 (M.D. Ala. Apr. 16, 1993) (mem.), a case with facts, a procedural setting, and applicable law identical, for analytical purposes, to *HHC*'s. The *Haynes* court granted defendant Department's motion for summary judgment. This ruling is consistent with the arguments set forth in this Comment, and contrary to the holding in *HHC*.

added); cf. *Batterton v. Francis*, 432 U.S. 416, 425 (1977) ("Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term."); *Beal v. Doe*, 432 U.S. 438, 444 (1977) ("language [of Medicaid Act] confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act") (footnote omitted).

¹¹² See *Pines*, *supra* note 34, at 54 (*HHC* decision was "awaited by health care providers in some 30 other states that have imposed similar cuts").

